Senate Bill 519

Handouts from the Department of Administration
Health Care and Benefits Division
Connie Welsh, Administrator

February 22, 2007

For the Senate Committee on Business, Labor, and Economic Affairs

1. Basic Plan History – 1999, 2000, 2001
2. Basic Plan History – 2002, 2003 (final year)
3. State of Utah Information Sheet on HSA Program
4. HDHP/HSA "Top 8 Collection Tips" (from the American Academy of Family Physicians)

Exhibit II - A

Income and Expenses
By Traditional, Basic, HMO and CHO Medical Plans

Category (1)	January 1, 2000 through March 31, 2000		April 1, 2000 through June 30, 2000		July 1, 2001 through September 30, 2001		October 1, 2001 through December 31, 2001		January 1, 2001 through December 31, 2001		January 1, 2000 through December 31, 2000		January 1, 1999 through December 31, 1999	
	Total $	Monthly Amount Per Eligible	Total $	Monthly Amount Per Eligible	Total $	Monthly Amount Per Eligible	Total $	Monthly Amount Per Eligible	Total $	Monthly Amount Per Eligible	Total $	Monthly Amount Per Eligible	Total $	Monthly Amount Per Eligible
Traditional														
Average Eligible		13,383		13,408		13,407		13,373		13,393		10,649		11,460
Contributions	$ 12,378,648	$ 308.31	$ 12,389,630	$ 308.02	$ 12,377,062	$ 307.72	$ 12,349,840	$ 307.84	$ 49,495,180	$ 307.97	$ 35,589,687	$ 278.52	$ 35,955,503	$ 261.45
Interest Income	$ 341,190	$ 8.50	$ 415,311	$ 10.33	$ 99,663	$ 2.48	$ 303,594	$ 7.57	$ 1,159,757	$ 7.22	$ 1,235,674	$ 9.67	$ 1,308,156	$ 9.51
Total Revenue	$ 12,719,838	$ 316.81	$ 12,804,941	$ 318.35	$ 12,476,725	$ 310.20	$ 12,653,434	$ 315.41	$ 50,654,937	$ 315.19	$ 36,825,361	$ 288.19	$ 37,263,659	$ 270.96
Expenses:														
Benefits Cost (2)	$ 11,516,718	$ 286.84	$ 13,803,737	$ 343.18	$ 14,733,788	$ 366.31	$ 15,775,444	$ 393.23	$ 55,829,687	$ 347.39	$ 41,784,342	$ 327.00	$ 40,050,322	$ 291.22
Other (3)	$ 866,208	$ 21.57	$ 909,568	$ 22.61	$ 822,677	$ 20.45	$ 805,968	$ 20.09	$ 3,404,421	$ 21.18	$ 1,879,396	$ 14.71	$ 1,895,944	$ 13.79
Total Expenses	$ 12,382,926	$ 308.42	$ 14,713,305	$ 365.79	$ 15,556,465	$ 386.77	$ 16,581,412	$ 413.32	$ 59,234,108	$ 368.57	$ 43,663,739	$ 341.70	$ 41,946,265	$ 305.01
Estimated Operating Addition/(Deficit)	$ 336,912	$ 8.39	$ (1,908,364)	$ (47.44)	$ (3,079,741)	$ (76.57)	$ (3,927,978)	$ (97.91)	$ (8,579,171)	$ (53.38)	$ (6,838,378)	$ (53.52)	$ (4,682,606)	$ (34.05)
Basic														
Average Eligible		1,336		1,348		1,327		1,323		1,334		885		921
Contributions	$ 1,131,883	$ 282.34	$ 1,141,502	$ 282.27	$ 1,121,735	$ 281.70	$ 1,118,359	$ 281.84	$ 4,513,479	$ 282.04	$ 2,751,075	$ 259.14	$ 2,662,760	$ 241.06
Interest Income	$ 31,198	$ 7.78	$ 38,264	$ 9.46	$ 9,032	$ 2.27	$ 27,492	$ 6.93	$ 105,987	$ 6.62	$ 95,615	$ 9.01	$ 97,166	$ 8.80
Total Revenue	$ 1,163,081	$ 290.12	$ 1,179,766	$ 291.73	$ 1,130,767	$ 283.97	$ 1,145,851	$ 288.77	$ 4,619,466	$ 288.66	$ 2,846,690	$ 268.15	$ 2,759,926	$ 249.86
Expenses:														
Benefits Cost (2)	$ 632,844	$ 157.86	$ 720,727	$ 178.22	$ 679,947	$ 170.76	$ 955,792	$ 240.87	$ 2,989,310	$ 186.80	$ 1,742,594	$ 164.15	$ 1,426,874	$ 129.18
Other (3)	$ 86,491	$ 21.57	$ 91,448	$ 22.61	$ 81,445	$ 20.45	$ 79,717	$ 20.09	$ 339,101	$ 21.19	$ 156,095	$ 14.70	$ 152,243	$ 13.78
Total Expenses	$ 719,336	$ 179.43	$ 812,175	$ 200.83	$ 761,392	$ 191.21	$ 1,035,509	$ 260.96	$ 3,328,411	$ 207.99	$ 1,898,689	$ 178.85	$ 1,579,117	$ 142.96
Estimated Operating Addition/(Deficit)	$ 443,745	$ 110.69	$ 367,591	$ 90.90	$ 369,375	$ 92.76	$ 110,343	$ 27.81	$ 1,291,055	$ 80.68	$ 948,001	$ 89.30	$ 1,180,808	$ 106.90
HMO (4)	Not applicable.		Not applicable.		Not applicable.		Not applicable.		Not applicable.		Not applicable.			
Average Eligible														867
Contributions													$ -	$ -
Interest Income													$ -	$ -
Total Revenue													$ -	$ -
Expenses:														
Benefits Cost (2)														
Other (3)														
Est. Settlement													$ 307,170	$ 29.52
Total Expenses													$ -	$ -
Estimated Operating Addition/(Deficit)													$ -	$ -
													$ 307,170	$ 29.52
CHO													$ (307,170)	$ (29.52)
Average Eligible		110		110		109		110		110		3,069		2,320
Contributions (5)	$ 109,462	$ 331.70	$ 108,772	$ 330.61	$ 107,471	$ 327.66	$ 107,615	$ 326.11	$ 433,320	$ 329.02	$ 11,211,397	$ 304.48	$ 7,610,288	$ 273.39
Expenses:														
Premium (5)	$ 96,850	$ 293.48	$ 91,379	$ 277.75	$ 94,631	$ 288.51	$ 94,312	$ 285.79	$ 377,172	$ 286.39	$ 10,503,288	$ 285.24	$ 6,855,343	$ 246.27
Other (3)	$ 4,296	$ 13.02	$ 3,907	$ 11.87	$ 3,631	$ 11.07	$ 3,653	$ 11.07	$ 15,487	$ 11.76	$ 382,779	$ 10.40	$ 284,300	$ 10.21
Total Expenses	$ 101,146	$ 306.50	$ 95,286	$ 289.62	$ 98,262	$ 299.58	$ 97,965	$ 296.86	$ 392,659	$ 298.15	$ 10,886,067	$ 295.64	$ 7,139,643	$ 256.48
Estimated Operating Addition/(Deficit)	$ 8,316	$ 25.20	$ 13,486	$ 40.99	$ 9,209	$ 28.08	$ 9,650	$ 29.24	$ 40,661	$ 30.87	$ 325,330	$ 8.84	$ 470,645	$ 16.91

(1) Some figures may not add due to rounding.
(2) Includes prescription drugs paid through Express Scripts. Does not include prescription drug rebates.
(3) Traditional, Basic, HMO: Includes managed care (individual managed care, managed care administration, psych managed care, EAP managed care and "health screenings"), vision exam and administration (medical fees and operating expenses). CHO: Includes EAP, vision exam and operating expenses.
(4) December 1998 enrollment used for 1999 HMO enrollment.
(5) CHO contributions include CHO billed amount, adverse selection load, impact of blended employee rates and "Other" costs attributable to CHO. CHO Premium includes CHO billed amount only.

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Exhibit III: Income & Expense by Indemnity Medical Plans

Category	January 1, 2004 through March 31, 2004		April 1, 2004 through June 30, 2004		July 1, 2004 through September 30, 2004		October 1, 2004 through December 31, 2004		January 1, 2004 through December 31, 2004		January 1, 2003 through December 31, 2003		January 1, 2002 through December 31, 2002	
	Total $	Monthly Amount Per Eligible	Total $	Monthly Amount Per Eligible	Total $	Monthly Amount Per Eligible	Total $	Monthly Amount Per Eligible	Total $	Monthly Amount Per Eligible	Total $	Monthly Amount Per Eligible	Total $	Monthly Amount Per Eligible
Basic Plan														
Average Eligible												1,281		1,296
Revenues:														
Contributions	$ 455		$ -		$ -		$ -		$ 455		$ 5,806,766	$ 377.82	$ 4,873,051	$ 313.40
Interest Income	$ 2		$ -		$ -		$ -		$ 2		$ 36,964	$ 2.41	$ 69,451	$ 4.47
Total Revenue	$ 457	Basic Plan Not Offered for 2004	$ -	Basic Plan Not Offered for 2004	$ -	Basic Plan Not Offered for 2004	$ -	Basic Plan Not Offered for 2004	$ 457	Basic Plan Not Offered for 2004	$ 5,843,729	$ 380.23	$ 4,942,502	$ 317.87
Expenses:														
Medical Claims	$ 244,826		$ 26,266		$ 12,833		$ 723		$ 284,648		$ 2,419,252	$ 157.41	$ 2,102,859	$ 135.24
Rx Claims	$ 2,018		$ 452		$ 283		$ -		$ 2,753		$ 650,740	$ 42.34	$ 600,975	$ 38.65
Managed Care	$ -		$ -		$ -		$ -		$ -		$ 103,060	$ 6.71	$ 102,129	$ 6.57
Admin / Operating	$ -		$ -		$ -		$ -		$ -		$ 280,998	$ 18.28	$ 258,239	$ 16.61
Total Expenses	$ 246,844		$ 26,717		$ 13,116		$ 723		$ 287,400		$ 3,454,050	$ 224.74	$ 3,064,203	$ 197.07
Estimated Operating Addition/(Deficit)	$ (246,387)		$ (26,717)		$ (13,116)		$ (723)		$ (286,943)		$ 2,389,679	$ 155.49	$ 1,878,299	$ 120.80
Loss Ratio												59.1%		62.0%
Traditional Plan														
Average Eligible		11,677		11,568		11,528		11,430		11,551		11,893		12,675
Revenues:														
Contributions	$ 14,726,375	$ 420.37	$ 14,542,062	$ 419.02	$ 14,496,638	$ 419.18	$ 14,365,667	$ 418.93	$ 58,130,741	$ 419.38	$ 56,442,042	$ 395.50	$ 51,567,959	$ 339.04
Interest Income	$ 71,088	$ 2.03	$ 64,039	$ 1.85	$ 41,161	$ 1.19	$ 103,851	$ 3.03	$ 280,138	$ 2.02	$ 343,230	$ 2.41	$ 679,379	$ 4.47
Total Revenue	$ 14,797,462	$ 422.40	$ 14,606,100	$ 420.86	$ 14,537,798	$ 420.37	$ 14,469,518	$ 421.96	$ 58,410,878	$ 421.40	$ 56,785,272	$ 397.91	$ 52,247,337	$ 343.50
Expenses:														
Medical Claims	$ 11,010,299	$ 314.29	$ 9,797,113	$ 282.30	$ 10,536,426	$ 304.67	$ 11,592,381	$ 338.06	$ 42,936,219	$ 309.76	$ 41,509,277	$ 290.86	$ 46,602,978	$ 306.39
Rx Claims	$ 2,766,254	$ 78.96	$ 3,142,868	$ 90.56	$ 3,314,898	$ 95.85	$ 3,907,556	$ 113.95	$ 13,131,575	$ 94.74	$ 12,690,119	$ 88.92	$ 12,276,111	$ 80.71
Managed Care	$ 193,856	$ 5.53	$ 260,574	$ 7.51	$ 173,615	$ 5.02	$ 212,175	$ 6.19	$ 840,221	$ 6.06	$ 956,971	$ 6.71	$ 999,041	$ 6.57
Admin / Operating	$ 543,943	$ 15.53	$ 529,073	$ 15.24	$ 735,494	$ 21.27	$ 659,468	$ 19.23	$ 2,467,977	$ 17.81	$ 2,609,228	$ 18.28	$ 2,526,122	$ 16.61
Total Expenses	$ 14,514,352	$ 414.32	$ 13,729,628	$ 395.61	$ 14,760,432	$ 426.81	$ 16,371,579	$ 477.43	$ 59,375,992	$ 428.36	$ 57,765,595	$ 404.78	$ 62,404,252	$ 410.28
Estimated Operating Addition/(Deficit)	$ 283,110	$ 8.08	$ 876,472	$ 25.25	$ (222,634)	$ (6.44)	$ (1,902,061)	$ (55.47)	$ (965,113)	$ (6.96)	(980,324)	$ (6.87)	(10,156,915)	$ (66.78)
Loss Ratio		98.1%		94.0%		101.5%		113.1%		101.7%		101.7%		119.4%
Total Indemnity														
Average Eligible		11,677		11,568		11,528		11,430		$ 11,550.92		13,173		13,971
Total Revenue	$ 14,797,919	$ 422.41	$ 14,606,100	$ 420.86	$ 14,537,798	$ 420.37	$ 14,469,518	$ 421.96	$ 58,411,336	$ 421.40	$ 62,629,001	$ 396.19	$ 57,189,839	$ 341.12
Expenses:														
Medical & Rx Claims	$ 14,023,397	$ 400.30	$ 12,966,698	$ 373.63	$ 13,864,440	$ 400.90	$ 15,500,659	$ 452.03	$ 56,355,194	$ 406.57	$ 57,269,388	$ 362.28	$ 61,582,923	$ 367.33
Other Costs	$ 737,799	$ 21.06	$ 789,647	$ 22.75	$ 909,109	$ 26.29	$ 871,643	$ 25.42	$ 3,308,198	$ 23.87	$ 3,950,257	$ 24.99	$ 3,885,531	$ 23.18
Total Expenses	$ 14,761,196	$ 421.36	$ 13,756,346	$ 396.38	$ 14,773,548	$ 427.19	$ 16,372,302	$ 477.45	$ 59,663,392	$ 430.44	$ 61,219,646	$ 387.27	$ 65,468,455	$ 390.50
Estimated Operating Addition/(Deficit)	$ 36,723	$ 1.05	$ 849,755	$ 24.49	$ (235,750)	$ (6.82)	$ (1,902,784)	$ (55.49)	$ (1,252,056)	$ (9.03)	$ 1,409,355	$ 8.92	$ (8,278,616)	$ (49.38)
Loss Ratio		99.8%		94.2%		101.6%		113.2%		102.1%		97.7%		114.5%

Notes:

Some figures may not add due to rounding.

Basic plan not offered for 2004. Claims reported are runout from prior periods.

Rx claims are net of rebates.

Medcial claims include capitation costs

"Managed Care" includes BCBS managed care, certification review, individual managed care, EAP and health screenings.

"Admin / Operating" includes Weight Watchers, smoking cessation, spring fitness, wellness, claims administration & state operating expenses

For comparison, 2002 and 2003 data have been updated and restated to reflect current allocation methodology for interest income, and administrative and operating expenses.

Consumer Directed Health Plans—State of Utah
by Linn Baker

This past legislative session a bill was drafted that mandated the Public Employees Health Program (PEHP) to offer a high deductible health plan with a health savings account to State employees. PEHP made the following analysis to see what the potential impact would be on the traditional health plans offered to employees. This analysis was provided to key legislators interested in the bill.

Analysis For Health Savings Account (HAS) and High Deductible Health Plan (HDHP)
State of Utah Employees 2005-06 Policy Year

Potential impact of offering HAS and HDHP to State employees

The following analysis is based on paid claims for single State employees for the period of July 1, 2005 to June 30, 2006. A base line (deductible) of $1,000.00 and $2,000.00 was used. The Public Employees Health Program (PEHP) (an in house self-administered health plan) selected all paid claims for those employees whose total claims were less than $1,000.00, and all those employees whose total claims were more than $1,000.00. The same process was used for a $2,000.00 deductible. PEHP wanted to know how the total risk pool could be impacted if the HDHP was offered.

Key factors

*The average annual premium for the three health plans offered to the single employee was $4,081.23.
*When the total risk pool was evaluated, single, two, and family coverage, PEHP found that 17% of its employees used 87% of the claims dollars.
*The Legislative mandate would require PEHP to fund 65% of the deductible.

Claims distribution

$1,000.00 deductible for single coverage

- 4,888 employees with total paid claims of $18,210,673.00
- Total annual claims less than $1,000.00
  - *2,186 employees with paid claims of $692,410.00
  - *Average annual cost for each employee $316.75
- Total annual claims more than $1,000.00
  - *2,702 employees with paid claims of $17,518,263.00
  - *Average annual cost for each employee $6,483.44

$2,000.00 deductible for single coverage

- 4,888 employees with total paid claims of $18,210,673.00
- Total annual claims of less than $2,000.00
  - *2,981 employees with paid claims of $1,837,591.00
  - *Average annual cost for each employee $616.43
- Total annual claims more than $2,000.00
  - *1,907 employees with paid claims of $16,373,082.00
  - *Average annual cost for each employee $8,585.78

Conclusions:

- When funding the HAS any amount that exceeded the average cost of *those most likely to enroll in the plan* would be an additional cost to the state.
- If the premium for the high deductible health plan *exceeded the actual experience* of those with costs less than the deductible it would be an increased cost to the state.
- If all those employees with the costs less than the deductible enrolled in the plan, and the State continued to pay for costs in excess of the deductible, the total costs for the risk pool would increase.
- Most of the care required by members with costs exceeding the deductible is *not discretionary*.
- Cost and quality data for episodes of care from various providers in the State is not available for employees seeking care.
- HDHP would have little impact on the vast majority of the claims dollars because they exceed the annual out-of-pocket maximums found in traditional coverage and the HDHP.

- Premiums in the traditional plans would increase dramatically.

The legislators did pass the mandate, however, they allowed PEHP to set the premium so that the younger and healthier employees continued to fund those with chronic health problems in traditional coverage. Our initial enrollment in the program was 5 employees out of 22,500 eligible. This low enrollment was a result of the employee's premium share for the other plans being very low.

High-Deductible Health Plan / Health Savings Account (HSA)
Top 8 Collection Tips

An HSA is a tax advantage savings account that is paired with a high-deductible health plan (HDHP) and can be used to pay for what the Internal Revenue Code defines as "qualified medical expenses." Preventive services may be paid for by the health plan with first dollar coverage.

As consumers become increasingly financially responsible for paying for medical services, physician practices' billing and collection processes will become even more important. Be mindful that just because a patient has a HDHP / HSA does not automatically mean that the account is funded adequately or even at all.

The top 8 HDHP / HSA collection tips for in-network physicians are to...

1. **Collect the deductible and/or coinsurance at time of service.**
   Negotiate with payers to be contractually able to collect any out-of-pocket monies due at the time of service. It will be helpful to know what the contracted rate for the provided service is so that the correct amount is collected at the time of service. Many practice management systems are able to maintain this data.

2. **Verify benefits and any financial obligations prior to visit.**
   Know the contractual rules on collections. Some preventive services may be the health plan's obligation even before the patient's deductible has been satisfied.

3. **Identify the member ID card.**
   Most HDHP / HSA member id cards will not indicate any copayment information with the exception of a possible copayment for preventive care.

4. **Save patient's HSA debit card and credit card number.**
   At check-in or check-out, ask patients for their HSA debit card and a credit card number so one of them can be used for any patient financial obligation indicated on the payer's explanation of benefit.

5. **Encourage patients to authorize automatic debiting.**
   Some health plans already have this option, which allows the patients to authorize money to be transferred from their HSA directly to a medical provider as soon as the insurer determines the patients' financial obligation. Patients would coordinate with the financial entity handling the HSA. Note, the HSA funds may be inadequate to pay for the delivered care.

6. **Collect past-due amounts in the office.**
   Be sure to collect any outstanding balances from patients who are in the office for another appointment.

7. **File electronic claims within 24 hours.**
   This will decrease the possibility of an increase in accounts receivable.

8. **Set payment policy.**
   Set a billing standard and stick with it except in hardship cases. An end result may be to dismiss patients who have significant overdue accounts.

Resources:

- Rod Aymond, Monitoring Your Practice's Financial Data: 10 Vital Signs, *Family Practice Management,* Jul/Aug 1999, http://www.aafp.org/fpm/990700fm/42.html.
- Robert Lowes, Collecting just got harder, *Medical Economics*, May 20, 2005.
- US Treasury Department - All About HSAs - http://www.treas.gov/offices/public-affairs/hsa/pdf/hsa-basics.pdf

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THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

October 2006

Health Savings Accounts and High Deductible Health Plans: Are They An Option for Low-Income Families?

Catherine Hoffman and Jennifer Tolbert

EXECUTIVE SUMMARY

Health Savings Accounts are a type of medical savings account that allow consumers to save for medical expenses on a tax-free basis. They are linked with high deductible health plans (HDHPs), and together these insurance and savings options represent a new approach to health care, commonly referred to as consumer-directed care. Health Savings Accounts (HSAs) were federally enacted as part of the Medicare Prescription Drug Improvement and Modernization Act of 2003.

To establish an HSA a consumer must enroll in an HDHP that meets certain requirements. In 2006, an HSA-qualifying HDHP must have a deductible of at least $1,050 for single coverage and $2,100 for family coverage. The plan must also limit the total amount of out-of-pocket cost-sharing for covered benefits each year to $5,250 for single coverage and $10,500 for families.

Compared to more traditional insurance plans, HDHPs generally require greater out-of-pocket spending, although the premiums may be lower. HSAs offer consumers a way to save for these higher expected health care costs. A key advantage of an HSA is that it belongs to the individual who establishes it and is portable. Funds that are not withdrawn in a year can be rolled over and used in future years. Once the HSA is exhausted however, there are no further tax advantages to help defray additional out-of-pocket expenses.

HSA-qualified health plans are currently a small segment of the health insurance market. In 2006, about 1.4 million employees are enrolled in HSA-qualified HDHPs offered by their employers; and at least another 855,000 people are covered in the nongroup market.

While HSAs and their associated HDHPs have been forwarded as one solution to increasing health care coverage and reducing overall health care costs, a key question is whether these HSAs and HDHPs represent a viable health insurance option for low-income families. Analyses of available data and relevant research suggest that HSAs and HDHPs are no more affordable for low-income families than existing plans, and the high deductibles associated with these plans may shift even more health care costs onto them.

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KEY FINDINGS:

Premiums for HSA-qualified health plans may be lower than for traditional insurance, but these plans shift more of the financial risk to individuals and families through higher deductibles.

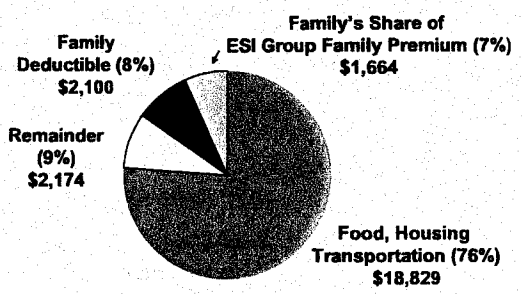
Compared to all group health plans, premiums for HSA-qualified HDHPs were about 30 percent lower in the group market in 2005. They are lower, in part, because the deductibles are much higher. The average deductible for an HSA-qualified health plan offered by employers was nearly six times higher than that for a PPO, the most common plan type.

HDHP premiums may be lower in the nongroup market on average than in the group market. However, because employers do not contribute toward a nongroup premium, the out-of-pocket costs for an individual or family are much greater. The average annual premium for an HSA-qualified HDHP in the nongroup market in 2005 (based on data from policies sold through eHealthinsurance) was $3,324 for family coverage and would be paid completely out-of-pocket. In contrast, a family's out-of-pocket share for an HSA-qualified HDHP premium offered through an employer averaged $1,664 in 2005.

Premiums and out-of-pocket costs for HSA-qualified health plans would consume a substantial portion of a low-income family's budget.

For a family with an annual income of about $25,000, the basic needs of food, housing, and transportation consume three-quarters of their household budget. Assuming their employer contributes to their premium costs, but in this case not to an HSA, this family's share of the average premium for an HSA-qualified HDHP in the group market would require 7 percent of their income. If the family were to save $2,100, the HSA required minimum family deductible amount, the combined premium and savings account would consume 15 percent of their income—leaving the family about $2,200 a year for all expenses beyond their basic needs.

Low-Income Household Expenditures Including HSA-HDHP <u>Group</u> Premium, with Savings for a Minimum Deductible



Average income in $20,000 to $30,000 range = $24,767

Source: Group market premium from Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005.
Calculated based on income/expenditure data from BLS Consumer Expenditure Survey, 2004.

In contrast, for a family without employer-based coverage who is purchasing an HSA-qualified HDHP in the nongroup market, the premium alone would consume 13 percent of the budget. After putting aside $2,100 in savings to cover health costs under the minimum deductible, such a family would be left with about $500 for the remainder of their household expenses in a year.

The potential out-of-pocket costs in HSA-qualified high deductible plans could be much higher than those in traditional insurance. By law, the minimum family deductible in 2006 is now $2,100. However, average deductibles are nearly two to three times higher than the required minimum, depending on whether the plan is in the group or nongroup market.

When the increased out-of-pocket costs for HSA-qualified HDHPs are considered along with the premiums, these plans are unaffordable for low-income families. Many of these families already face significant medical debt and have difficulty paying medical bills. High deductible plans for low-income families would do little to alleviate this burden.

Most low-income individuals and families do not face high enough tax liability to benefit in a significant way from tax deductions associated with HSAs.

According to data from the U.S. Department of the Treasury, a family of four with an income of $20,000 would receive no benefit from contributing any amount to an HSA. In contrast, a family of four making $120,000, would accrue $620 in tax savings from contributing $2,000 to an HSA. Coupled with the limited ability of low-income families to save money, the failure of HSAs to offer any real financial benefits for these families further reduces the likelihood that these plans will be attractive to low-income families.

People with chronic conditions, disabilities, and others with high-cost medical needs may face even greater out-of-pocket costs under HSA-qualified health plans.

People with chronic conditions and disabilities often experience higher medical costs than those without these conditions. For example, the total health care costs for individuals with asthma, heart disease, and diabetes are more than double that of nonelderly adults in general. As a result, these individuals are much more likely to reach their deductible level each year, which by design, is set at a much higher level in HDHPs.

Health Savings Accounts and HDHPs are likely to be more attractive to healthy individuals and families who have had few major medical expenses. If the healthiest increasingly enroll in HSA-qualified HDHPs while persons with chronic conditions and those with higher medical expenses remain in existing health plans, the premiums for traditional coverage will rise accordingly for the least healthy.

Cost-sharing reduces the use of health care, especially primary and preventive services, and low-income individuals and those who are sicker are particularly sensitive to cost-sharing increases.

Studies have found that increased cost-sharing leads to decreased health care use. Sentinel research from the RAND Health Insurance Experiment found that people enrolled in cost-sharing health plans were significantly less likely to see a doctor for services (including general health and vision exams and treatment for infections) than people who were enrolled in health plans with no cost-sharing—and the gap was greater for those with low incomes (<200 percent of the poverty level). The study also found that low-income individuals in poor health who were subject to cost-sharing versus those who were not, experienced poorer health outcomes on certain measures, including the risk of dying for those with heart disease risk factors.

Health savings accounts and high deductible plans are unlikely to substantially increase health insurance coverage among the uninsured.

Over two-thirds of the nonelderly uninsured are low-income. Because they earn so little, over half of the uninsured have no tax liability. As such, health insurance proposals that rely on tax deductions as an incentive will have limited impact on the number of uninsured. In addition, high deductible health plans that require higher out-of-pocket spending will not offer the low-income uninsured enough financial protection to offset the premium cost.

CONCLUSION

Health Savings Accounts and associated high deductible plans have generated a great deal of interest among policymakers as a potential mechanism for reducing health care costs and perhaps even expanding access to health insurance. While HSA-qualified health plans have not been available long enough to fully assess their effect, salient research and analyses suggest that the benefit of these plans to low-income individuals and families will be minimal. Despite having lower premiums than more traditionally-structured health plans, HSA-qualified HDHPs are still likely to be unaffordable for most low-income families. These families have limited funds available to cover the higher out-of-pocket spending required of HSA-qualified HDHPs and are also unlikely to benefit from the tax-deductibility of HSA contributions.

By encouraging individuals and families to choose high deductible health plans and set up HSAs, it is assumed that consumers will eventually become more cost-conscious, enabling them to make more cost-effective decisions about their health and health care. However, most low-income individuals and families are already making these tougher cost-benefit decisions as each health need arises. And the research to date shows that unaffordable cost-sharing among the low-income population not only decreases access to needed care but, in some circumstances, can also lead to poorer health. For low-income families in particular, HSAs and HDHPs may exacerbate, rather than alleviate, the problems they currently face in affording and accessing needed health care.

kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

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Health Savings Accounts and High Deductible Health Plans: Are They An Option for Low-Income Families?

Catherine Hoffman and Jennifer Tolbert

EXECUTIVE SUMMARY

Health Savings Accounts are a type of medical savings account that allow consumers to save for medical expenses on a tax-free basis. They are linked with high deductible health plans (HDHPs), and together these insurance and savings options represent a new approach to health care, commonly referred to as consumer-directed care. Health Savings Accounts (HSAs) were federally enacted as part of the Medicare Prescription Drug Improvement and Modernization Act of 2003.

To establish an HSA a consumer must enroll in an HDHP that meets certain requirements. In 2006, an HSA-qualifying HDHP must have a deductible of at least $1,050 for single coverage and $2,100 for family coverage. The plan must also limit the total amount of out-of-pocket cost-sharing for covered benefits each year to $5,250 for single coverage and $10,500 for families.

Compared to more traditional insurance plans, HDHPs generally require greater out-of-pocket spending, although the premiums may be lower. HSAs offer consumers a way to save for these higher expected health care costs. A key advantage of an HSA is that it belongs to the individual who establishes it and is portable. Funds that are not withdrawn in a year can be rolled over and used in future years. Once the HSA is exhausted however, there are no further tax advantages to help defray additional out-of-pocket expenses.

HSA-qualified health plans are currently a small segment of the health insurance market. In 2006, about 1.4 million employees are enrolled in HSA-qualified HDHPs offered by their employers; and at least another 855,000 people are covered in the nongroup market.

While HSAs and their associated HDHPs have been forwarded as one solution to increasing health care coverage and reducing overall health care costs, a key question is whether these HSAs and HDHPs represent a viable health insurance option for low-income families. Analyses of available data and relevant research suggest that HSAs and HDHPs are no more affordable for low-income families than existing plans, and the high deductibles associated with these plans may shift even more health care costs onto them.

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KEY FINDINGS:

Premiums for HSA-qualified health plans may be lower than for traditional insurance, but these plans shift more of the financial risk to individuals and families through higher deductibles.

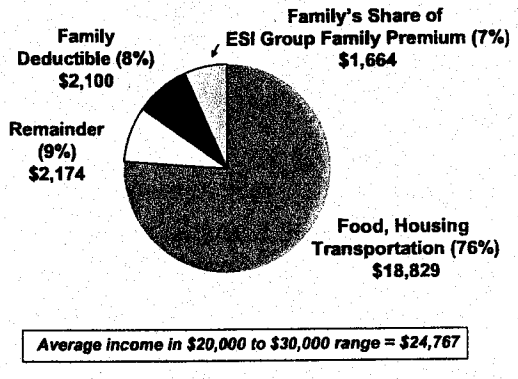
Compared to all group health plans, premiums for HSA-qualified HDHPs were about 30 percent lower in the group market in 2005. They are lower, in part, because the deductibles are much higher. The average deductible for an HSA-qualified health plan offered by employers was nearly six times higher than that for a PPO, the most common plan type.

HDHP premiums may be lower in the nongroup market on average than in the group market. However, because employers do not contribute toward a nongroup premium, the out-of-pocket costs for an individual or family are much greater. The average annual premium for an HSA-qualified HDHP in the nongroup market in 2005 (based on data from policies sold through eHealthinsurance) was $3,324 for family coverage and would be paid completely out-of-pocket. In contrast, a family's out-of-pocket share for an HSA-qualified HDHP premium offered through an employer averaged $1,664 in 2005.

Premiums and out-of-pocket costs for HSA-qualified health plans would consume a substantial portion of a low-income family's budget.

For a family with an annual income of about $25,000, the basic needs of food, housing, and transportation consume three-quarters of their household budget. Assuming their employer contributes to their premium costs, but in this case not to an HSA, this family's share of the average premium for an HSA-qualified HDHP in the group market would require 7 percent of their income. If the family were to save $2,100, the HSA required minimum family deductible amount, the combined premium and savings account would consume 15 percent of their income—leaving the family about $2,200 a year for all expenses beyond their basic needs.

Low-Income Household Expenditures Including HSA-HDHP Group Premium, with Savings for a Minimum Deductible



Source: Group market premium from Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005. Calculated based on income/expenditure data from BLS Consumer Expenditure Survey, 2004.

In contrast, for a family without employer-based coverage who is purchasing an HSA-qualified HDHP in the nongroup market, the premium alone would consume 13 percent of the budget. After putting aside $2,100 in savings to cover health costs under the minimum deductible, such a family would be left with about $500 for the remainder of their household expenses in a year.

The potential out-of-pocket costs in HSA-qualified high deductible plans could be much higher than those in traditional insurance. By law, the minimum family deductible in 2006 is now $2,100. However, average deductibles are nearly two to three times higher than the required minimum, depending on whether the plan is in the group or nongroup market.

When the increased out-of-pocket costs for HSA-qualified HDHPs are considered along with the premiums, these plans are unaffordable for low-income families. Many of these families already face significant medical debt and have difficulty paying medical bills. High deductible plans for low-income families would do little to alleviate this burden.

Most low-income individuals and families do not face high enough tax liability to benefit in a significant way from tax deductions associated with HSAs.

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